EVALUATION OF THE CERTIFICATE OF NEED APPLICATION SUBMITTED BY FRANCISCAN HEALTH SYSTEM PROPOSING TO ESTABLISH A 112-BED HOSPITAL IN THE CITY OF GIG HARBOR, WITHIN PIERCE COUNTY

PROJECT DESCRIPTION

Franciscan Health System (FHS) is part of a larger organization known as Catholic Health Initiatives that owns 118 health care facilities in 22 states. Catholic Health Initiatives does not have direct ownership or management of any facilities in Washington State. Franciscan Health System or one of its subsidiaries currently owns or operates a variety of health care facilities in the state--three hospitals, three dialysis centers,[1] a skilled nursing facility, an ambulatory surgery center, a Medicare certified hospice agency, and a hospice care center. The health care facilities are listed below.[2] [source: CN historical files and Application, p2]

HOSPITALS
St. Joseph Medical Center, Tacoma
St. Clare Hospital, Lakewood
St. Frances Hospital, Federal Way

HOSPICE AGENCY
Franciscan Hospice, Tacoma

HOSPICE CARE CENTER
FHS Hospice Care Center

SKILLED NURSING FACILITY
Franciscan Care Center, Tacoma

DIALYSIS CENTERS
Greater Puyallup Dialysis Center, Puyallup
St. Joseph Dialysis Facility, Tacoma
Gig Harbor Dialysis Center, Gig Harbor

AMBULATORY SURGERY CENTER
Gig Harbor Ambulatory Surgery Center

This project proposes to establish a 112-bed hospital in the city of Gig Harbor, within Pierce County. For ease of reference, the proposed hospital will be referred to as FHS-GH throughout this evaluation. FHS proposes that FHS-GH will be a satellite hospital of its St. Joseph Medical Center (SJMC) located in Tacoma. FHS-GH will be licensed under the existing hospital license of SJMC, this would result in a total licensed bed capacity of 432 (SJMC-320; FHS-GH-112). [source: Application, p2]

The proposed site for FHS-GH has not yet been issued an address; however, the general description of the site is ½ mile north of the intersection of Burnham Road and Canterwood Drive in the city of Gig Harbor. The legal description of the proposed site is:

> *"the portion of the following described property located east of 58th Avenue Northwest (Canterwood Drive Northwest):*
> *a portion of the southeast quarter of section 25, township 22 north, range 1 east, W.M. Pierce County, Washington."* [source: Application p52, Exhibit 6, p17]

FHS proposes that the establishment of FHS-GH will be in two phases, which are described below. [source: Application, pp14-16 and October 8, 2003, Supplemental Information, pp3-4]

Phase One:

This phase includes the build out of space for 80 inpatient beds. Of the 80 beds, 64 would be located in medical/surgical inpatient space, and 16 would be located in the intensive and

[1] FHS submitted an application to establish a fourth dialysis center within Pierce County. As of the writing of this evaluation, a decision on that project is not yet available. An application has also been submitted for an ambulatory surgery center project where FHS has partial ownership. A decision on that project is not yet available.
[2] FHS Hospice Care Center is a recently approved project and not yet operational.

coronary care units. Along with the 80 beds would be the establishment of the following services:

Service/Department	Description
Short stay/outpatient	15 outpatient beds (not counted in bed license)
Emergency	Urgent and emergent treatment rooms
Surgery	Major and minor procedure rooms
Diagnostic Imaging	Exam rooms fro radiology, fluoroscopy, chest, mammography, CT scanner, MRI, and ultrasound
Pulmonary Function	Test and treatment area
Nuclear Medicine	Exam room
Cardiac	Diagnostic catheterization laboratory and non-invasive testing area
Rehabilitation Services	PT gym, PT, speech, OT, and cardiac rehab treatment spaces
Laboratory Services	Full inpatient laboratory services, including surgical pathology
Pharmacy Services	Inpatient dispensing and mixing pharmacy

Phase one also includes the cost and construction to shell-in space for the remaining 32 beds. Phase one would commence by July 2005, and the above services would be available by July 2007. The first full year of operation as an 80-bed hospital is year 2008.

Phase Two:

This phase includes the completion of the shelled-in space for the 32 remaining beds and obtaining licensure for those beds. FHS states that phase two would commence approximately year 2010 and be complete approximately year 2012. Commencement of phase two is dependant on the 80-bed hospital's utilization.

The capital expenditure associated with construction of the hospital is $94,563,078. This amount includes both phases of the project.

APPLICABILITY OF CERTIFICATE OF NEED LAW

This project is subject to Certificate of Need review as the establishment of a new health care facility under the provisions of Revised Code of Washington (RCW) 70.38.105(4)(a) and Washington Administrative Code (WAC) 246-310-020(1)(a).

APPLICATION CHRONOLOGY

June 17, 2003	Letter of Intent Submitted
August 12, 2003	Application Submitted
August 13, 2003, thru October 19, 2003	Department's Pre-Review Activities • 1st screening activities and responses • public comments accepted throughout this phase
October 20, 2003	Department Begins Review of Application
January 29, 2004	Public Hearing Conducted/End of Public Comment
February 18, 2004	Rebuttal Documents Submitted to Department
March 12, 2004	Pivotal Unresolved Issue (PUI) Declared
March 22, 2004	Applicant's Response to PUI
April 7, 2004	Affected Parties Rebuttal to Applicant's PUI Response

May 5, 2004 Department's Anticipated Decision Date
May 14, 2004 Department's Actual Decision Date

AFFECTED PERSONS

The following three entities sought and received affected person status under WAC 246-310-010:

1. Harrison Memorial Hospital, a two-campus hospital located in the cities of Bremerton and Silverdale within Kitsap County;
2. Good Samaritan Hospital, located in the city of Puyallup, within Pierce County; and
3. MultiCare Health System, which owns and operates three hospitals in Pierce County.[3]
   - Tacoma General/Allenmore Hospital, a two-campus hospital located in the city of Tacoma,
   - St. Clare Hospital, located in the city of Lakewood within Pierce County; and
   - Mary Bridge Children's Health Center, a pediatric hospital located within the footprint of the Tacoma General facility. Mary Bridge provides acute care services primarily to patients 0-18 years of age.

SOURCE INFORMATION REVIEWED

- Franciscan Health System's August 12, 2003, Certificate of Need Application
- Franciscan Health System's October 10, 2003, supplemental information
- Community members' comments received throughout the review
- Documents and comments received from community members at the January 29, 2004, public hearing
- Harrison Memorial Hospital's January 28, 2004, public comments
- MultiCare Health System's January 29, 2004, public comments
- Franciscan Health System's February 18, 2004, rebuttal comments
- Harrison Memorial Hospital's February 18, 2004, rebuttal comments
- MultiCare Health System's February 18, 2004, rebuttal comments
- Franciscan Health System's March 22, 2004, response to the department's Pivotal Unresolved Issue (PUI)
- Harrison Memorial Hospital's April 7, 2004, rebuttal comments to FHS's PUI response
- MultiCare Health System's April 7, 2004, rebuttal comments to FHS's PUI response
- Comprehensive Hospital Abstract Reporting System (CHARS) data obtained from the Department of Health's Office of Hospital and Patient Data Systems
- Historical charity care data obtained from the Department of Health's Office of Hospital and Patient Data Systems (2000, 2001, and 2002 summaries)
- Financial feasibility and cost containment evaluation prepared by the Department of Health's Office of Hospital and Patient Data Systems (April 30, 2003, analysis)
- Population data obtained from the Office Financial Management based on year 2000 census published January 2002.
- Licensing and/or survey data provided by the Department of Health's Office of Health Care Survey
- Emergency and trauma designation data provided by the Department of Health's Office of Emergency Medical and Trauma Prevention
- Acute Care Bed Methodology extracted from the 1987 State Health Plan
- Data obtained from Franciscan Health System's website

[3] Multicare Health System also owns and operates St. Francis Hospital located in the city of Federal Way within King County.

SOURCE INFORMATION REVIEWED (continued)

- Data obtained from the Internet regarding health care worker shortages in Washington State
- Data obtained from the Internet regarding mileage and distance
- Certificate of Need Historical files

CRITERIA EVALUATION

To obtain Certificate of Need approval, Franciscan Health System must demonstrate compliance with the criteria found in WAC 246-310-210 (need); 246-310-220 (financial feasibility); 246-310-230 (structure and process of care); and 246-310-240 (cost containment), and portions of the 1987 State Health Plan as it relates to the acute care bed methodology.[4]

CONCLUSION

For the reasons stated in this evaluation, the Certificate of Need application submitted on behalf of Franciscan Health System proposing to establish a 112-bed acute care hospital in the city of Gig Harbor within Pierce County is not consistent with applicable criteria of the Certificate of Need Program. However, the establishment of an 80-bed acute care hospital in the city of Gig Harbor is consistent with those criteria. With this acute care bed reduction, the project meets the relevant criteria for the project, provided that the applicant agrees to the following term(s) and condition:

TERMS:

To ensure that appropriate ancillary and support agreements will be established at FHS-GH, the applicant must agree to the following terms:

1) Prior to providing services at FHS-GH, FHS will provide functional plans outlining the services to be provided through FHS, SJMC, and on site at FHS-GH.
2) Prior to providing services at FHS-GH, FHS will identify the proposed medical director at FHS-GH and provide an executed copy of the medical director agreement.

At such time that Franciscan Health System provides the department with a copy of a determination of non-significance or final environmental impact statement pertaining to the site for the hospital, the department will issue a Certificate of Need for the project with the following condition.

CONDITION:

As a two-campus hospital, the hospital in total must provide charity care in compliance with the charity care policies provided in this Certificate of Need application and the requirements of the applicable law. Specifically, both FHS-SJMC and FHS-Gig Harbor will use reasonable efforts to provide charity care in an amount comparable to the average amount of charity care provided by all hospitals in the Puget Sound Region during the three most recent years. For historical years 2000-2002, these amounts are 1.6% of gross revenue, and 3.8% of adjusted revenue. FHS-SJMC and FHS-GH will maintain records at each facility documenting the amount of charity care it provides and demonstrating compliance with its charity care policies and applicable law.

[4] Each criterion contains certain sub-criterion. The following sub-criteria are not discussed in this evaluation because they are not relevant to this project: WAC 246-310-210(3), (4), (5), and (6).

A. Need (WAC 246-310-210)

Based on the source information reviewed, the department determines that the applicant has met the need criteria in WAC 246-310-210(1) and (2).

(1) The population served or to be served has need for the project and other services and facilities of the type proposed are not or will not be sufficiently available or accessible to meet that need.

The determination of numeric need for acute care hospital beds is performed using the Hospital Bed Need Forecasting Method contained in the 1987 Washington State Health Plan (SHP). Though the SHP was "sunset" in 1989, the department has concluded that this methodology remains a reliable tool for predicting the baseline need for acute care beds.

The 1987 methodology was a revision of an earlier projection methodology prepared in 1979 and used in the development of subsequent State Health Plans. This methodology was developed as a planning tool for the State Health Coordinating Council (SHCC) to facilitate long-term strategic planning of health care resources. The methodology is a flexible tool, capable of delivering meaningful results for a variety of applications, dependent upon variables such as referral patterns, age-specific needs for services, and the preferences of the users of hospital services, among others.

The 1987 methodology is a twelve-step process of information gathering and mathematical computation. The first four steps develop trend information on hospital utilization. The next six steps calculate baseline non-psychiatric bed need forecasts. The final two steps are intended to determine the total baseline hospital bed need forecasts, including need for short-stay psychiatric services: step 11 projects short-stay psychiatric bed need, and step 12 is the adjustment phase, in which any necessary changes are made to the calculations in the prior steps to reflect conditions which might cause the pure application of the methodology to under- or over-state the need for acute care beds.

The completed methodology is presented as a series of appendices to this evaluation. The methodology presented here incorporates all adjustments that were made following preparation of the methodology. Where necessary, both adjusted and un-adjusted computations are provided. The methodology uses population and healthcare use statistics on several levels: statewide, Health Service Area (HSA) [5], and planning area. The planning area for this evaluation is Central Pierce County located in HSA 1.[6]

This portion of the evaluation will describe, in summary, the calculations made at each step and the assumptions and adjustments made in that process. The titles for each step are excerpted from the 1987 SHP.

[5] The state is divided into four HSA's by geographic groupings. HSA 1 is composed of Clallam, Island, Jefferson, King, Kitsap, Pierce, San Juan, Skagit, Snohomish, and Whatcom Counties. HSA 2 is composed of Clark, Cowlitz, Grays Harbor, Klickitat, Lewis, Mason, Pacific, Skamania, Thurston, and Wahkiakum counties. HSA 3 is composed of Benton, Chelan, Douglas, Franklin, Grant, Kittitas, Okanogan, and Yakima Counties. HSA 4 is composed of Adams, Asotin, Columbia, Ferry, Garfield, Lincoln, Pend Oreille, Spokane, Stevens, Walla Walla, and Whitman counties.

[6] Described in 1981 by Puget Sound Health Systems Agency as zip codes 98303, 98333, 98335, 98349, 98351, 98388, 98394, 98395, 98401, 98402, 98403, 98404, 98405, 98406, 98407, 98408, 98409, 98411, 98416, 98421, 98422, 98424, 98443, 98465, 98466, and 98467.

Step 1: Compile state historical utilization data (i.e., patient days within major service categories) for at least ten years proceeding the base year.

For this step, attached as Appendix 1, the department obtained utilization data for 1996 through 2002 from the Department of Health's Office of Hospital and Patient Data Systems' CHARS (Comprehensive Hospital Abstract Reporting System) database. Total patient days were identified for the Central Pierce Planning Area, HSA 1, and Washington State as a whole, excluding psychiatric patient days [Major Diagnostic Category (MDC) 19] and normal newborns [Diagnostic Related Group (DRG) 391], according to the county in which care was provided. Normal newborn days (DRG 391) were excluded because the normal newborn patients (babies) do not occupy a licensed acute care bed. The mothers of the normal newborns are included in the patient days (MDC 14 and DRG 370-384).

The limitation of this table to seven years' data, rather than ten years' data, is discussed in step 4, below.

Step 2: Subtract psychiatric patient days from each year's historical data.

While this step was partially accomplished by limiting the data obtained for Step 1, above, the remaining data still included non-MDC 19 patient days spent at psychiatric hospitals. Patient days at dedicated psychiatric hospitals were identified for each year and subtracted from each year's total patient days. The adjusted patient days are shown in Appendix 2.

Step 3: For each year, compute the statewide and HSA average use rates.

The average use rate (defined as the number of patient days per 1,000 population) was derived by dividing the total number of patient days in each HSA by that HSA's population and multiplied by 1,000. For the purposes of this application, the average use rate was also determined for the Central Pierce planning area and is attached as Appendix 3. Actual and projected population figures for this analysis were derived from the Washington State Office of Financial Management (OFM) "medium-series" county population projections, based on the 2000 census, developed January 2002[7], and from Central Pierce County population data provided by the applicant.

Step 4: Using the ten-year history of use rates, compute the use rate trend line, and its slope, for each HSA and for the state as a whole.

The department has previously determined that changes in the healthcare delivery system occurring in the first few years of the most recent ten years, such as changes in the federal Medicare reimbursement system and increasing application of managed care principles, were responsible for a sharp decline in use rates during the period 1993-1995. It is the department's conclusion that these factors represent an adjustment in the delivery of healthcare that is unlikely to be duplicated in the near future. As a result, the department has concluded that the period 1996-2002 more accurately represents use rates at present and for the foreseeable future. Consequently, the department computed trend lines for the state, HSA 1, and the Central Pierce planning area based upon the trends in use rates from these seven years and included them as Appendix 4. The resulting trend lines uniformly exhibit a mild upward slope. This conclusion is supported by increasing utilization reported by hospitals throughout the state in recent years, and is indicative of a growing population.

[7] Found on the World Wide Web at http://www.ofm.wa.gov/pop902020/pop902020toc.htm.

More significant than overall population growth is the fact that the state's population is growing older as the large number of "baby boomers" (those born from 1946 to 1964) age and begin to demand more health services. Utilization of hospital beds by patients aged 65 and older is significantly higher than bed utilization by younger patients, as demonstrated in subsequent calculations.

Step 5: Using the latest statewide patient origin study, allocate non-psychiatric patient days reported in hospitals back to the hospital planning areas where the patients live. (The psychiatric patient day data are used separately in the short-stay psychiatric hospital bed need forecasts.)

The previous four steps of the methodology involved data identified by the planning area where care was provided. In order to determine the need for services for residents of a given planning area, patient days must be identified, instead, by the area *where the patients live*. Step 5, included as Appendix 5, identifies referral patterns in and out of the Central Pierce planning area and illustrates where residents of the planning area currently receive care. For this calculation, the department separated patient days by age group (0-64 and 65 and older), and subtracted patient days for residents of other states. The department also used hospital discharge data obtained from the Oregon Department of Human Services to identify patient days for Washington residents obtaining health care in Oregon (the department is not aware of similar data for the state of Idaho).

As has been noted earlier, the original purpose for this methodology was to create comprehensive, statewide resource need forecasts. For purposes of this evaluation, the state was broken into only two planning areas – Central Pierce and the state as a whole *minus* Central Pierce. Appendix 5 illustrates the age-specific patient days for residents of the Central Pierce planning area and for the rest of the state, identified here as "WA – Central Pierce."

Step 6: Compute each hospital planning area's use rate (excluding psychiatric services) for each of the age groups considered (at a minimum, ages 0-64 and 65+).

Appendix 6 illustrates the age-specific use rates for the year 2002, as defined in Step 3, for the Central Pierce planning area and for the rest of the state.

Step 7A: Forecast each hospital planning area's use rates for the target year by "trend-adjusting" each age-specific use rate. The use rates are adjusted upward or downward in proportion to the slope of either the statewide ten-year use rate trend or the appropriate health planning region's ten-year use rate trend, whichever trend would result in the smaller adjustment.

As discussed in Step 4, the department concluded that the seven-year use rate trends for 1996-2002 reflect the behavior of Washington residents more accurately than the ten-year use rate trends for 1993-2002. The 2002 use rates determined in Step 6 were multiplied by the slopes of both the planning area's seven-year use rate trend line and by the slope of the statewide seven-year use rate trend line for comparison purposes. For the Central Pierce planning area, the area trend is a higher rate of increase (an annual increase of 9.985) than the statewide rate (an annual increase of 3.9784). As directed in Step 7A, the department applied the statewide trend to project future use rates. By applying the use rate trend that differs least from the current use rate, the methodology uses the most conservative of trended use rates.

The methodology is designed to project need in a specified "target year." The applicant has indicated that the first phase of this project will be implemented in 2007, with the second phase completed in 2012. It is the practice of the department to evaluate need for a given project through at least three years following completion of the project. However, within this application, FHS provided information only through completion of phase one--2010. For this project, 2010 is the target year for the calculations in Appendices 7 through 9. For this project, the department chose to use the methodology to project need for the Central Pierce planning area over a series of years--from 2002 to 2022. The department's projections are presented in the summary attached as Appendix 10 of this analysis.

Step 8: Forecast non-psychiatric patient days for each hospital planning area by multiplying the area's trend-adjusted use rates for the age groups by the area's forecasted population (in thousands) in each age group at the target year. Add patient days in each age group to determine total forecasted patient days.

Using the forecasted use rate for the sample target year 2010 and OFM population projections, projected patient days for Central Pierce planning area residents are illustrated in Appendix 8. As noted in Step 7 above, forecasts have been prepared for a series of years and are presented in summary in Appendix 10 as "Total Central Pierce Res Days."

Step 9 Allocate the forecasted non-psychiatric patient days to the planning areas where services are expected to be provided in accordance with (a) the hospital market shares and (b) the percent of out-of-state use of Washington hospitals, both derived from the latest statewide patient origin study.

Using the patient origin study developed for Step 5, Appendix 9 illustrates how the projected patient days for the Central Pierce planning area and the remainder of the state were allocated from county of resident to the area where the care is projected to be delivered in the target year 2010. The results of these calculations are presented in Appendix 10 as "Total Days in Central Pierce Hospitals."

Step 10: Applying weighted average occupancy standards, determine each planning area's non-psychiatric bed need. Calculate the weighted average occupancy standard as described in Hospital Forecasting Standard 11.f. This should be based on the total number of beds in each hospital (Standard 11.b), including any short-stay psychiatric beds in general acute-care hospitals. Psychiatric hospitals with no other services should be excluded from the occupancy calculation.

The number of beds in the planning area was identified in accordance with the SHP standard 12.a., which states:

1. beds which are currently licensed and physically could be set up without significant capital expenditure requiring new state approval;
2. beds which do not physically exist but are authorized unless for some reason it seems certain those beds will never be built;
3. beds which are currently in the license but physically could not be set up (e.g., beds which have been converted to other uses with no realistic chance they could be converted back to beds);
4. beds which will be eliminated.

SHP determines the number of available beds in each HSA, by including only those beds that meet the definition of #1 and #2 above, plus any CN approved beds. This information was gathered through a survey of existing facilities, and adjusted, as necessary, by comparison of the survey results with CN and Facilities and Services Licensing records.

For this application, SJMC reported 320 beds either set up or assignable and not set up. Of these 320 beds, 18 are designated for psychiatric services. As a result, SJMC's total of available beds is 302 (320 less 18). Mary Bridge Children's Health Center did not respond to the department's survey, but a review of historical information provided to OHPDS indicates that all 72 of Mary Bridge's beds are available. The remaining hospital in the planning area, Tacoma General/Allenmore Hospital (TG/A), did not respond to the survey provided by the department. Rather, TG/A offered an alternate response format, in which it indicated that 380 of the beds located at TG/A's two campuses *"…are currently licensed and physically could be set up without significant capital expenditure requiring new state approval."* TG/A also indicated that an additional 141 beds *"…do not physically exist but are authorized unless for some reason it seems certain those beds will never be built."* TG/A asserts that all 521 of its beds should be counted as available beds. The department disagrees with TG/A's assertion that all 521 beds should be considered available for purposes of future capacity planning because the definition under #2 above describes beds for which an approved Certificate of Need exists, but has not yet been executed. Since no unexecuted certificates exist for TG/A, and TG/A has clearly differentiated these beds from those which physically could be set up without significant capital expenditure requiring new state approval, the department concludes that 141 beds of its 521 beds should be regarded as "beds which are in the current license but physically could not be set up." Therefore, 141 of TG/A's beds are not available for use. As part of making this determination, the department reviewed TG/A's annual reports to OHPDS. In the last five years, TG/A has consistently reported between 365 and 380 available beds.

Among the three hospitals in the Central Pierce planning area, the department concludes there are 754 available beds.[8]

The weighted occupancy standard for a planning area is defined by the SHP as the sum, across all hospitals in the planning area, of each hospital's occupancy rate times that hospital's percentage of total beds in the area. In previous evaluations, the department determined that the occupancy standards reflected in the 1987 SHP are higher than can be maintained by hospitals under the current models for provision of care. As a result, the department has adjusted the occupancy standards presented in the SHP downward by 5% for all but the smallest hospitals (1 through 49 beds). As a result of this change, the Central Pierce planning area's weighted occupancy has been determined to be 73.57%. This reduction in occupancy standards, along with the weighted occupancy standard assumptions detailed above, is reflected in the line "Wtd Occ Std" in Appendix 10.

While the methodology states that short-stay psychiatric beds should be included in the above total, the fact that all psychiatric patient days were excluded from the patient days analyzed elsewhere in the methodology makes their inclusion inconsistent with the patient days used to determine need.

[8] SJMC=302, Mary Bridge=72, TG/A=380.

Step 11: To obtain a bed need forecast for all hospital services, including psychiatric, add the non-psychiatric bed need from step 10 above to the psychiatric inpatient bed need from step 11 of the short-stay psychiatric hospital bed need forecasting method.

The applicant proposes no psychiatric services at the new facility. In addition, the short-stay psychiatric bed need methodology relies on admissions data from federal and state-owned hospitals, which are not available to the department. For these reasons, the department concluded that psychiatric services should not be forecast while evaluating this project.

Step 12: Determine and carry out any necessary adjustments in population, use rates, market shares, out-of-area use and occupancy rates, following the guidelines in section IV of this Guide.

Adjustments have been made where applicable and described above.

The department has concluded that some surplus capacity will be created during the early years of this project. This projected surplus is not considered to be an unnecessary duplication in that increased capacity cannot and should not be expected to be operating at full capacity in the first few years of operation. In addition, the expense of building acute care bed capacity is such that the lifecycle of the bed space should be evaluated over a time period similar to that of the amortization of the expense. The department concludes that it is not reasonable to build only enough beds to meet immediate need if, in the short run, enough need will exist to increase capacity beyond that initially constructed, and will result in a higher total cost than building adequate capacity to satisfy projected need in the near future.

As illustrated in Appendix 10, by 2012, the first year the applicant proposes to operate all 112 requested beds, the planning area is projected experience a shortage of beds, even with this project fully executed.

In summary, applying the acute care bed methodology's mathematical calculation indicates that the establishment of a hospital in Gig Harbor is reasonable. However, the result of the mathematical calculation is not the sole measure of determining need for a new hospital. The department must also consider documentation provided in support and opposition to this project.

Documentation Provided in Support of the FHS-GH Project

During the course of this review, the department received approximately 750 letters of support from central Pierce County residents, representatives of the local fire districts, and law enforcement officials. Common themes within the letters of support are summarized below:

- concerns with patients having to travel over the traffic-congested Tacoma Narrows Bridge to receive routine medical care;
- concerns with patients having to travel over the bridge to receive emergent medical care; and
- concerns with the growing population in the Gig Harbor and Key Peninsula areas resulting in increased traffic in the future.

In response to the information provided in support of the application, FHS states *"…these letters and public testimony have demonstrated the extent and magnitude of the access*

problems experienced daily by Gig Harbor and Key Peninsula residents. These access problems materialize in two distinct ways. The first problem is in physically getting to healthcare in downtown Tacoma. Secondly, and once "over the bridge," residents report being regularly diverted due to high census in one or both of the downtown Tacoma Hospitals. Additional health care resources are desperately needed to serve the residents of Gig Harbor and Key Peninsula."

[source: FHS February 18, 2004, rebuttal documents, p1]

Documentation Provided in Opposition to the FHS-GH Project

Concerns raised in opposition to this project were provided by MultiCare Health System on behalf of Tacoma General/Allenmore Hospital in Tacoma and Harrison Memorial Hospital (HMH) in Bremerton. The department has restated or summarized the concerns from both entities below:

- FHS undercounts the existing acute care bed supply--that number should be 913, not 895 as identified by the applicant [used in the acute care bed methodology].
- Weighted occupancy standards should be consistent with those identified in the SHP [and used in the acute care bed methodology].
- There is no need for a new hospital in the Gig Harbor and Key Peninsula area because other providers are both available and accessible. With the new Highway 16 bridge (Tacoma Narrows) to be built and operational before the project can be built, whatever perceived access issues existing now will be non-existent in 2007.
- Inpatient demand growth projections made by the applicant are based on erroneous assumptions and result in projections that are significantly higher than are realistic.

[source: Excerpts/summaries from public comments and rebuttal documents]

In response to the issues raised by both MultiCare and HMH, FHS provided the following statements:

- MultiCare argues that the bed supply at SJMC should be counted as 320, not the 302 identified in the application. SJMC has operated an 18-bed psychiatric unit for more than 28 years. To best serve the community, FHS intends to continue to operate that unit. Consistent with department past practices, FHS excluded both psychiatric patient days and psychiatric beds from our projection.
- In the late 1970's, when the bed-need methodology was developed, hospitals were able to sustain relatively high average occupancy levels. Today, because of payer admission patterns, shorter overall lengths of stay, increased specialization of units, and increased demand/use of emergency services, hospitals that average 75% occupancy are during peak times experiencing occupancy in excess of 100% of effective capacity. These high levels cannot and should not be sustained. The consequences of these high levels are already well known in some communities…and lead to unreasonable and potentially unsafe delays in accessing emergency care, bumping of selective surgical cases, or elective admissions, and an overall slow down in access to care. Consistent with the departments past practices, FHS adjusted the occupancy standard for each Central Pierce hospital down by five percentage points.
- MultiCare has attempted to argue that it has the capacity to meet the needs of Gig Harbor/Key Peninsula residents, both now and for the foreseeable future. However, it provided no data to substantiate this claim. The record is overflowing with stories of patients being diverted from both Tacoma General and SJMC. Clearly, and even setting aside the access problems, existing services and facilities--all of which are located in Tacoma--are insufficient to meet current and future needs. …while

MultiCare argues that existing capacity is sufficient to meet demand, [within its public comment documents], it references its "massive capital project to address the community's need." Again [within its public comment documents], it notes its needs to invest capital to make additional beds operational. MultiCare is inconsistent in its arguments. However, even assuming that MultiCare can make operational all 521 of its licensed beds, a bed need exists in the planning area by 2011.

- The phenomenon of hospitals and communities finding themselves with a shortage of licensed beds is well documented nationwide, and is exacerbated in the western states for several reasons. The first is because these states have historically had the lowest ratios of hospital beds to population of any states in the nation. Secondly, western states are growing faster, and are experiencing higher rates of net migration, than the rest of the nation. A study titled National and Local Impact of Long-Term Demographic Change on Inpatient Care was published in October 2002. [excerpts from the study provided in the FHS documentation provided the basis for FHS's conclusions]

  [source: FHS February 17, 2004, rebuttal documents, pp10-17]

After reviewing the information provided in support and opposition to this project and the responses provided by FHS, the department provides the following conclusions.

Weighted occupancy standards and the number of acute care beds counted in the methodology.

Regarding the weighted occupancy standards, this issue was adequately addressed under Step 10 of the acute care bed methodology portion of this evaluation. Additionally, FHS provided accurate and reasonable information from the acute care hospital perspective to respond to this concern.

Regarding the number of acute care beds to be counted in the methodology, FHS states that number should be 895[9] and MultiCare states that number should be 913.[10] This difference is the 18 beds currently licensed as acute care beds at SJMC and dedicated to psychiatric patient use. However, as noted in Step 10 [shown in Appendix 10] of the methodology, the department determined that neither of these were the accurate count of available beds in the central Pierce planning area. As noted in Step 10, the department concluded there are 754 available beds distributed among the three hospitals in the Central Pierce planning area. Explanation for this conclusion is provided and adequately addressed under Step 10 of the methodology.

Need for additional acute care beds in the planning area

As shown in Appendix 10 attached to this evaluation, application of the numeric portion of the acute care bed methodology shows a surplus of 91 acute care beds in the central Pierce planning area in year 2002. In year 2006, that surplus decreases to 29 beds. In year 2007, with phase one of the FHS-GH project implemented and 80 more beds in the planning area, the surplus returns to returns to 79 beds and then diminishes to 15 beds by year 2010--the end of the third year of operation for this project. By the end of year 2013 with both phases of the proposed project complete and all 112 beds operational in the planning area, the methodology would indicate need for an additional 28 beds. This is considered by the department to be a factor to determine need for additional bed capacity in the planning area.

[9] SJMC=302; Mary Bridge=72; TG/A=521.
[10] SJMC=320; Mary Bridge=72; TG/A=521.

Further, within the 754 beds counted by the department as available beds in the Central Pierce planning area are the 72 beds owned and operated by Mary Bridge Children's' Hospital (Mary Bridge) in Tacoma. Mary Bridge is a regional hospital that provides acute care services to pediatric patients--typically those patients between 0 and 18 years of age. The 72 beds represent 10% of the counted available beds in the planning area; however, Mary Bridges' 72 beds are available to only 25% of the population. Therefore, the number of beds needed in the central Pierce County planning area would be slightly more than the numeric methodology projects in Step 10 shown in Appendix 10.

There are two routes patients and/or ambulances can use to drive to Tacoma hospitals from Gig Harbor:

1) drive east across the Tacoma Narrows Bridge. This route is approximately 11 miles or 21 minutes.
2) drive slightly north, then south through Mason and Thurston counties and then north on Interstate 5 to Tacoma, in Pierce County. This route is approximately 93 miles and 2½ hours.

Even though Route 1 may require crossing the Tacoma Narrows Bridge during heavy traffic, it is still preferable to Route 2, which is circuitous and not considered a viable route for patients requiring health services. As a result, there is one viable route patients and/or ambulances can use to drive from Gig Harbor to Tacoma.

According to verifiable information provided within the application an expansion of the Tacoma Narrows Bridge is currently underway and scheduled for opening in 2007 and completion in 2008. The expansion consists of adding another span, resulting in a total of six lanes (three each way--one lane will be dedicated HOV[11]) and pedestrian facilities and shoulder areas on the bridge. Once the new bridge is operational, renovation to the existing bridge will begin, with a completion of this project approximately 2008. As a result, construction of both bridge projects will overlap for almost one year.

FHS predicts that the favorable results of the expansion project will be short-lived and the traffic issues will not be completely solved with a new bridge; conversely, MultiCare predicts that the results will be long-term and the majority of the existing traffic issues related to the bridge will be essentially non-existent.

According to documentation provided within the application, with both bridges operational, the notable improvement will be safer travel routes between Gig Harbor and Tacoma, rather than shorter travel routes. Addtionally, the addition of another bridge and more lanes will not influence traffic congestion due to slow downs related to accidents, weather, or vehicle breakdowns. Based on information reviewed regarding the bridge project, the department concludes that the new bridge will not be the end-all-save-all; however, it may provide some relief from traffic congestion--how much relief is yet to be seen and impossible to predict. Related to the traffic congestion issues, it is important to recognize that the new bridge merely adds two HOV lanes--one east bound and one west bound. It does not propose to ease traffic congestion for those vehicles that do not qualify as HOV traffic. The department also concludes that during the peak travel times, traffic congestion

[11] According to Tacoma Narrows Bridge project information, the HOV lane will be dedicated to vehicles with three or more passengers.

may be viewed as a barrier to provision of health care services for patients residing in the Gig Harbor/Key Peninsula areas, as well as emergency transport vehicles.

Shortage of Acute Care Beds in Washington State and Nationally

Research on this issue does not provide compelling data to demonstrate a shortage of acute care beds nationally and in Washington State as asserted by FHS. However, the research does demonstrate that there is an expected increase in acute care bed use by patients within the state and nationally. An increase in acute care bed use does not automatically mean that there is a *shortage* of beds. Based on the current methodology and existing trends within the state, an acute care bed shortage is not expected to occur in central Pierce County until year 2008. This shortage supports the applicant's assertion of need for 80 additional beds in the service area for year 2007.

In summary, while applying the acute care bed methodology's mathematical calculation indicates that the establishment of a hospital in central Pierce County may be reasonable, the department must also consider whether the applicant provided sufficient rationale to demonstrate need for an additional 112 beds.

As previously stated, FHS intends this project would be implemented in two phases. Phase one includes the build out of space for 80 inpatient beds and the cost and construction to shell-in space for the remaining 32 beds. Phase one would commence by July 2005, and the 80 beds would be operational by July 2007. The first full year of operation as an 80-bed hospital is year 2008. Phase two includes the completion of the shelled-in space for the 32 remaining beds and obtaining licensure for those beds. FHS states that phase two would commence "*approximately year 2010 and be complete approximately year 2012. Commencement of phase two is dependant on the 80-bed hospital's utilization*. " The capital expenditure associated with both phases of the project is $94,563,078. [source: Application, pp14-16 and October 8, 2003, Supplemental Information, pp3-4]

While FHS provided documentation to support additional bed capacity, the documentation supports only phase one of the project--the 80-bed hospital. The documentation includes:

- projected utilization--application guidelines require an applicant to provide its projected utilization for the first three years of operation following project completion. FHS provided its projected utilization for years 1, 2, and 3, consistent with years 2008, 2009, 2010, as an 80-bed hospital, which is the first three years of operation following completion of phase one. [source: Application, p17]
- financial pro forma information--as with projected utilization, application guidelines request pro forma information for three full fiscal years following project completion. Again, FHS provided its pro forma information for years 1, 2, and 3, consistent with years 2008, 2009, 2010, as an 80-bed hospital, which is the first three years of operation following completion of phase one. [source: Application, p124 and Exhibit 17]
- all assumptions relied on by FHS utilization and pro forma information--consistent with application requirements, FHS provided its assumptions and methodologies used to determine the projected utilization and pro forma financial information above. The assumptions and methodologies used by FHS include base data, volume, revenue, deductions from revenue, operating expenses, depreciation, and start up costs. All assumptions and methodologies used are based on an 80-bed hospital.[12] [source: Application, p148-150]

[12] Within the assumptions is a reference to St. Clare Hospital as being *"slightly larger than the projected size of the Gig Harbor Community Hospital campus."* St. Clare is a 106 bed acute care hospital.

- construction cost comparison--FHS provided a construction cost comparison for an 80-bed hospital, rather than a 112-bed hospital. [source: Application, p119]

Further, the State Health Plan (SHP) provides the occupancy guidelines for new hospitals to assist in determining the appropriate number of beds in a new facility. The guidelines state:

For the purposes of making resource forecasts, occupancy rates for proposed new hospitals shall not be less than:

- *50% for hospitals with an average daily census (ADC) of 25 or less;*
- *65% for hospitals with an ADC between 26 and 65;*
- *70% for hospitals with an ADC between 66 and 140;*
- *75% for hospitals with an ADC between 141 and 225; and*
- *80% for hospitals with an ADC of 226 or more.*

[source: State Health Plan, Standard D-Occupancy Standards for use in Resource Forecasts]

Table I below shows the projected ADC and occupancy rates for FHS-GH as an 80-bed facility.

Table I
FHS-GH Projected Average Daily Census and Occupancy Rates

	Year One (2008)	Year Two (2009)	Year Three (2010)
Number of Beds	80	80	80
Patient Days	14,421	16,445	18,680
Average Daily Census[13]	39.5	45.0	51.2
Projected Occupancy[14]	49%	56%	64%

Based on the guidelines, as an 80-bed hospital, FHS-GH's occupancy rate must be 65% by the end of year three. As shown in Table I above, FHS-GH's projected occupancy at the end of year three would be slightly below the guideline within the SHP.

Based on information provided in the application, the department concludes that need for an 80-bed hospital has been demonstrated by FHS. Therefore, the department concludes that the applicant has demonstrated need for 80 additional acute care beds in the central Pierce County planning area.

(2) All residents of the service area, including low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly are likely to have adequate access to the proposed health service or services.

All residents of the service area including low-income, racial and ethnic minorities, handicapped and other underserved groups currently have access to services at the healthcare facilities owned and operated by FHS. [source: CN historical files] To demonstrate compliance with this criterion for FHS-GH, FHS provided its current charity care policies and procedures and its current admission policies used by St. Joseph Hospital, St. Francis Hospital, and St. Clare Hospital. [source: Application, Exhibits 8 and 9] FHS states that the charity care and admission policies for the new hospital in Gig Harbor would be the same as those currently on file at all FHS hospitals. The admission policies provided demonstrate that patients are admitted to all FHS facilities for treatment without regard to age, race, color,

[13] Average Daily Census is calculated by dividing the projected number of patient days by 365.
[14] Projected Occupancy is calculated by dividing the projected number of patient days by 29,200. 29,200 is the number of beds (80) multiplied by 365.

religion, sex, national origin, handicap, or sexual preference and are treated with respect and dignity. The charity care policies provided in the application indicate that all FHS facilities accept patients for treatment and care regardless of the patient's ability to pay. Given that FHS anticipates FHS-GH to be licensed under the SJMC acute care license, separate admission and charity care policies for FHS-GH are not required. However, if, for whatever reason, FHS-GH is not licensed under SJMC's license, then separate admission and charity care policies are required.

For charity care reporting purposes, the Department of Health's Office of Hospital and Patient Data Systems (OHPDS), divides Washington State into five regions: King County, Puget Sound (less King County), Southwest, Central, and Eastern. FHS-GH will be located in Pierce County within the Puget Sound Region. According to 2000-2002[15] charity care data obtained from OHPDS, the three-year average for the Puget Sound Region is .92% for gross revenue and 1.80% for adjusted revenue. [source: OHPDS 2000-2002 charity care summaries] Additionally, two of the three hospitals operated by FHS are located in the Puget Sound Region--St. Joseph Medical Center in Tacoma, and St. Clare Hospital in Lakewood.[16] According to the 2000-2002 charity care data for these three hospitals, one FHS hospital--St. Joseph Medical Center--has historically provided charity care less than the Puget Sound Regional average, while the other has consistently provided charity care greater than the regional average.

FHS-GH pro formas indicate that the new hospital will provide charity care at approximately 1.6% of gross revenue, and 3.8% of adjusted revenue, which is higher than the average charity care provided in the Puget Sound Region. However, given that FHS expects to license the new hospital under the SJMC license and the inconsistent percentages of charity care provided by FHS hospitals, the department concludes that a condition related to the charity care is necessary to ensure that both campuses would provide the amount of charity care consistent with the average for the hospitals in the region. The condition is stated on page four of this evaluation.

Based on the information above and with the condition stated on page 4, the department concludes that all residents of the service area would have adequate access to the health services at FHS-GH.

B. Financial Feasibility (WAC 246-310-220)

Based on the source information reviewed, the department determines that the applicant has met the financial feasibility criteria in WAC 246-310-220.

(1) *<u>The immediate and long-range capital and operating costs of the project can be met.</u>*

To analyze short- and long-term financial feasibility of hospital projects and to assess the financial impact of a project on overall facility operations, the department uses financial ratio analysis. The analysis assesses the financial position of an applicant, both historically and prospectively. The financial ratios utilized are **1)** long-term debt to equity ratio; **2)** current assets to current liabilities ratio; **3)** assets financed by liabilities ratio; **4)** total operating expense to total operating revenue ratio; and **5)** debt service coverage ratio. If a project's ratios are within the expected value range, the project can be expected to be financially feasible.

[15] Year 2003 charity care data is not available as of the writing of this evaluation.
[16] FHS's St. Francis Community Hospital is located in the King County Region.

Table II below shows the financial ratios that FHS projects in the first three years of operation for FHS-GH with 80 of its 112 beds operational, and the Office of Hospital and Patient Data Systems (OHPDS) year 2002 financial ratio guidelines for hospital operations. [source: OHPDS analysis, pp3-4]

Table II
FHS-Gig Harbor's Projected Financial Ratios

Financial Ratio	OHPDS Guideline		Year 1 2008	Year 2 2009	Year 3 2010
Long Term Debt to Equity	0.575	* Below	2.531	2.425	2.175
Current Assets/Current Liabilities	1.791	* Above	1.435	1.490	1.546
Assets Financed by Liabilities	0.460	* Below	0.731	0.724	0.703
Total Operating Expense to Total Operating Revenue	0.975	* Below	1.045	0.995	0.952
Debt Service Coverage	3.448	* Above	1.025	1.299	1.622

** = a project is considered more feasible if the ratios are above or below the value/guideline as indicated*

As noted in Table II, FHS projects a worse than average financial position in all ratios in the first year of operation, and by the end of the third year of operation, the ratios are only slightly improved. After reviewing the financial information provided by FHS, staff from OHPDS stated the following:

> *"[FHS-GH] is projected to have 0.048% profit margin in CON Year 3, which is about average compared to Washington State hospitals. The new hospital is at or better than break-even by the end on the third year as required by CON rules. However, some of the [FHS-GH] for CON years 1 through 3 ratios are somewhat poor. The ratios are skewed because the numbers are for a new facility. In established hospitals, debt is acquired to expand or replace assets such as buildings or equipment upgrades. The debt may be in addition to older debt the hospital still carries. However, the hospital has had years to build up the equity in its facility. It has long ago paid off the land, some of the buildings or some renovations and therefore the hospital has assets without debt or current liabilities impairing them. [FHS-GH] in its first three years has not had that time to build up "net assets", or assets unencumbered by debt that these older facilities have. Also, the new hospital has not had years to build up its financial balance and cash flow with the profits from previous years of operation. It is important to note that [FHS-GH] will be part of St. Joseph Medical Center in Tacoma. When [OHPDS] looks at the financial ratios for the combined operations in 2010, they are all better than, or are within appropriate range, of the state 2002 figures."* [source: OHPDS analysis, p3]

As an 80-bed hospital, FHS projects 14,421 patient days in its first full year of operation (2008). Patient days are projected increase to 18,680 in year 2010, the third full year of operation. Table III on the following page details the projected revenues and expenses in the first three years of operation at FHS-GH as an 80-bed acute care hospital. [source: Application, Exhibit 17 and OHPDS analysis, pp4-5]

Table III
FHS-GH Projected Revenue and Expenses

	Year One (2008)	Year Two (2009)	Year Three (2010)
Patient Days	14,421	16,445	18,680
Net Patient Revenue	$ 35,897,436	$ 40,458,676	$ 45,485,185
Total Operating Expense*	$ 37,744,561	$ 40,065,015	$ 43,048,342
Net Profit or (Loss)	($ 1,847,125)	$ 393,661	$ 2,436,843
Net Revenue per Patient Day	$ 2,489.25	$ 2,460.24	$ 2,434.97
Net Expense per Patient Day	$ 2,617.33	$ 2,436.30	$ 2,304.52
Net Profit (Loss) per Patient Day	($ 128.09)	$23.94	$ 130.45

*Includes Overhead Expense

As shown in Table III above, FHS anticipates the new hospital would operate at a loss in the first year of operation, and then a minimal profit in the next two years.

Concerns raised by both MultiCare and HMH related to the financial feasibility criterion are summarized below. [source: HMH January 27,2004 public comments, p12; MultiCare January 28, 2004, public comments, p3]

- Operating costs and revenue projections are significantly flawed. This is due to [FHS's] use of inappropriate assumptions and methodologies resulting in grossly inflated long-term projections of inpatient hospital days to be required by residents of the area to be served and to be provided in this facility.
- FHS has also assumed unreasonable market share for such a limited service facility located in an area with nearby options for hospital care of all the same, as well as greater complexity and scope of services. A more realistic projection would result in fewer patient days for the area residents, plus lower market share for the proposed hospital (i.e. 50%) which would translate to substantially fewer patients at the proposed hospital, generating lower revenues and requiring greater financial subsidy and higher charges.
- …most egregious is the serious over-estimation of the expected revenues at the proposed project, based upon reasonable forecasts and trends of referral. [FHS] contends to achieve more than 100% of the expected patient days from the Gig Harbor/Peninsula area, an obvious impossibility, both numerically and because the market share of TG/A now averages 38.1% of the patients from the area and referral patterns are unlikely to change.

FHS provided the following statements in response to the above issues raised by both MultiCare and HMH. [source: FHS February 17, 2004, rebuttal documents, pp21-35; and FHS March 19, 2004, PUI responses, pp1-6]

- The new FHS-GH will in no way be limited service. It will provide comprehensive, needed inpatient services, with the following exceptions:
    - Tertiary services as defined in WAC 246-310-020: open heart surgery, [including non-emergent PTCA procedures as defined in WAC 246-310-262], bone marrow transplant, solid organ transplant, heart transplant, specialty burn services, level I rehabilitation services, and specialty pediatric services;
    - Obstetrics: a decision has been made not to include OB services due to the relatively low demand from the greater Gig Harbor Peninsula. A review of CHARS data notes that in 2002, less than 510 births occurred by Peninsula residents in Washington hospitals. Of this number,

approximately 13% were tertiary (level II or III) in nature. The State's 2001 Perinatal Guidelines consistent with American College of Obstetricians and Gynecologist suggest that urban hospitals should operate at higher volume levels than 400-500 births.

- Psychiatric services: a regional service is available at SJMC in Tacoma.

According to CHARS data, the above categories account for about 25% of all greater Gig Harbor area patient days. In other words, 75% of all patient care needs will be able to be met locally when the hospital is operational.

- FHS started with a 42.4% market share (actual 2002 for the service lines to be offered locally), and then grew market share.
- For those service lines that FHS will offer at the new hospital, and 8.2% annual increase in patient days within the greater Gig Harbor planning area was assumed. Per CHARS, 8.2% is the actual annual rate of growth for these service lines within the greater Gig Harbor planning area over the past five years.
- FHS assumed in-migration equal to its existing market share from south and central Kitsap County and north Mason County.

Central Kitsap

FHS already has a 2% market share for those services it intends to operate at the new hospital. FHS projects a 1.5% market share to the new hospital.

South Kitsap

FHS already has an 8.69% market share for those services it intends to operate at the new hospital. Year 2002 CHARS data indicates that MultiCare had a 6.42% market share and HMH had a 65.83% market share. 19% of patient days for the services we propose to offer locally go to other hospitals--predominately Seattle. FHS estimates that its market share will increase from 8.69% to 16.52%. This assumption is based on three factors: **1)** a reduction in the percentage of patients who opt to travel over the Tacoma Narrow Bridge to MultiCare hospitals; **2)** a reduction in the percentage of patients who opt to travel to Seattle for care that will be available locally; and **3)** a shift of patients from Harrison to the new hospital. FHS has not quantified the exact magnitude of each of these three sources. It is, however, reasonable to assume that each of the three might be equally impacted. With these assumptions, MultiCare, HMH, and Seattle hospitals would each be reduced by 2.6 points. HMH market share would be reduced from 65.83% to 63.23%--a nearly 4% decline.

Mason County

FHS already has a 1.97% market share for those services it intends to operate at the new hospital. FHS assumed a 1.5% market share to the new hospital (75% of 2%). Therefore, no impact is projected on Mason General Hospital.

After reviewing the information provided by both HMH and MultiCare and the responses provided by FHS, the department concludes the following.

The department recognizes the difficulty in determining a potential impact to existing providers when a new hospital is established in an area where no hospital previously exists, however, the basis for the calculations and formulas used by FHS to determine its market shares, resulting in its projected patient days and revenues at FHS-GH are based on verifiable, historical CHARS data. Based on the services proposed to be provided at FHS-GH, the market share assumptions appear to be reasonable.

Using the applicant's formula for determining the impact to HMH, if this project is approved HMH's market share of south Kitsap patients would be reduced to 63.23%. Based on the

projected impact, HMH would continue to have the majority market share of the Kitsap County patients. Addtionally, of the 750 letters of support, 13, or 1.7%, were received from Kitsap County residents. The department concludes that the projected impact to HMH is reasonable and would not negatively affect the viability of the hospital.

Applying the same formula to MultiCare's existing market share of 6.42% of south Kitsap patients results in a 3.85% market share. As noted, MultiCare's market share of Kitsap County residents is small, therefore, it is reasonable to assume that MultiCare does not rely heavily on those Kitsap County patients to sustain the viability of the hospital. The potential impact to MultiCare would not negatively affect the viability of TG/A.

In summary, the department concurs that the projected impact on market share as a result of the approval would not negatively affect the viability of Mason General Hospital, TG/A, or HMH. Additionally, staff concludes that FHS would be able to meet its short and long term financial obligations, and the capital and operating costs of the project would be met. This sub-criterion is met.

(2) *The costs of the project, including any construction costs, will probably not result in an unreasonable impact on the costs and charges for health services.*

OHPDS also compared FHS-GH's costs and charges to the year 2002 statewide average and determined that they are reasonable. [source: OHPDS analysis, p6]

As previously stated, the capital expenditure to complete both phases of FHS-GH is $94,563,078. Table IV below shows a breakdown of those construction costs as an 80-bed hospital. [source: Application, p119]

Table IV
FHS-GH Capital Cost Breakdown

Total Capital Costs	$ 94,563,078
Construction Cost	$ 82,305,503
Gross Square Footage	197,038
Beds/Stations/Other (Unit)	80
Total Const. per Gross Square Foot	$ 475
Total Cost per Unit	$ 1,182,038

After reviewing the construction costs for the project, staff from OHPDS stated the following:

> *"Construction costs can vary quite a bit due to the type of construction, quality of material, custom vs. standard design, building site, and other factors. The costs shown [above] are within the past construction costs reviewed by this office."* [source: OHPDS analysis, p6]

Based on the information provided above, the department concludes that the cost of the project, including the construction costs identified in the application, will not result in an unreasonable impact on the costs and charges for health services within the service area. This sub-criterion is met.

(3) *The project can be appropriately financed.*

As stated in the project description portion of this evaluation, FHS proposes to establish the 112-bed hospital in two phases. Phase I is the establishment of 80 beds and shelling in space for the remaining 32 beds. Phase two is completion of shelled-in space and the adding the remaining 32 beds to the hospital license. The total capital expenditure for both

phases is $94,563,078. The chart below shows a breakdown of the capital costs. [source: Application, p117]

FHS-GH Capital Cost Breakdown

Land Purchase	$ 1,279,567
Construction Costs	61,078,353
Fixed Equipment	8,981,998
Moveable Equipment	9,086,722
Architect & Engineering Fees	4,975,594
Site Preparation	3,158,430
Sales Tax	6,002,414
Total	$ 94,563,078

FHS states that funding for the project would be from the following two sources:

- FHS accumulated reserves for $18,912,616 or 20% of the total costs; and
- CHI internal loan for $75,640,462 or 80% of the total costs.

[source: Application, p120]

To demonstrate that both FHS and CHI have the funds necessary to finance the project, FHS provided CHI's most recent financial statements (year 2002) and FHS's most recent financial statements (June 2002 and unaudited June 2003). [source: Application, Appendix 1; October 8, 2003, supplemental information, Attachment 4; and CHI website] After reviewing the financial data staff from OHPDS provided the following evaluation. [source: OHPDS analysis, pp2-4]

> *"Franciscan Health System-West is committing a moderate size amount of the corporations' assets to this project. FHS-West will use reserves for its portion of the capital expenditure [$18,912,616]. Analysis shows that FHS-West has the funds available. The use of these reserves is very inexpensive. Reserves are accumulated mainly from prior year profits or debt acquisition. The only cost would be that the money would not be available for other uses.*
>
> *Catholic Health Initiatives is committing a small amount of the corporations' assets on this purchase. CHI states that its funds will come through a debt program administered at the CHI national office. CHI states that hospitals do not access the capital markets individually; rather, all tax-exempt borrowing is done at the System level, with loans made from the national office to the CHI hospitals. The interest rate of the loan is determined by the System in accordance with its cost of capital.*
> [source: August 7, 2003, response-Geraldine M. Hoyler, SVP, CHI Finance and Treasury]

FHS's capital expenditure is projected to be $18,912,616 or 20% of the total cost of the project. This amount equates to 5.06% of the FHS total assets and 20.38% of the FHS board designated assets. FHS has undergone tremendous growth in the last couple of years. Since January 2003, FHS received approval to:

- establish a new dialysis center in Gig Harbor (February 11, 2003), and
- establish a new 20 bed hospice care center in Tacoma (August 25, 2003); and
- establish a new ASC in Gig Harbor (March 12, 2004).

All of these projects have had some impact on the general financial health of FHS, however, further review shows that while this project will also have a considerable impact to FHS, total assets were $374 million and board designated assets were $93 million for audited year 2002. Therefore, while this project will have a considerable impact on FHS's board designated

assets, it will not adversely impact the reserves, total assets, total liability, or the general financial health of FHS in a significant way.

CHI's capital expenditure is projected to be $75,650,462 or 80% of the total cost of the project. This amount equates to 1.04% of CHI's total assets and 2.5% of its board designated assets for FYE June 2003. For FYE June 2003, CHI's total assets were $7.2 billion and board designated assets were $3.02 billion. This project will not have a significant impact to CHI's board designated assets, reserves, total assets, total liability or general financial health in a significant way. Further, if necessary, CHI has adequate reserves to fund the entire project directly; therefore, the department concludes that the proposed financing is appropriate and this sub-criterion is met.

C. Structure and Process (Quality) of Care (WAC 246-310-230)

Based on the source information reviewed and with agreement to the terms outlined on page 4 of this evaluation, the department determines that the applicant has met the structure and process (quality) of care criteria in WAC 246-310-230.

(1) A sufficient supply of qualified staff for the project, including both health personnel and management personnel, are available or can be recruited.

FHS anticipates that the 80-bed hospital will require 259 employed and contracted FTEs in year one, with an increase of 24 FTEs in year two, and another increase of 27 FTEs in year three. The three-year total FTEs is expected to be 310 FTEs. A breakdown of FTEs for the first three years of operation is shown in Table V below.

Table V
FHS-GH Proposed FTEs

FTE	Year 1	Year 2 Increase	Year 3 Increase	TOTAL
Management	8.97	0.83	0.94	10.74
Technical Staff	59.21	5.49	6.17	70.87
RN's	75.03	6.95	7.82	89.80
LPN's	3.49	0.32	0.36	4.17
CNA's	21.08	1.95	2.20	25.23
Other Exempt Staff[17]	7.73	0.72	0.81	9.26
Other Non-Exempt Staff[18]	83.49	7.74	8.70	99.93
TOTAL FTES	**259**	**24**	**27**	**310**

FHS states that in excess of 400 FHS-West employees, including more than 200 SJMC employees, reside in the Gig Harbor/Peninsula area. FHS expects that some of these employees will choose to transfer to the new hospital. FHS states that it does not anticipate major problems in recruiting staff needed to open and operate the new campus, rather, FHS expects the challenge to be recruiting and maintaining staff for SJMC in Tacoma. To ensure both FHS facilities will have adequate FTEs available and to minimize the impact on other existing hospitals in Pierce County, FHS plans to rely on its historical recruitment and retention practices summarized below.

- FHS offers, and will continue to offer, a generous benefit package for both full and part time employees;

[17] Exempt staff may include administration, clerical, billing, and supervisory staff.
[18] Non-exempt staff may include housekeeping, nutrition, and a variety of in-training staff.

- FHS currently contracts with nearly 30 technical colleges, community colleges, and four-year universities throughout the Unites State for training and/or job opportunities;
- FHS monitors the 'wage' market, and adjusts its wages as necessary to ensure its hospital's wage structures remain competitive;
- nursing residency programs are offered for both new nursing graduates and nurses interested in changing specialties;
- FHS partners with Pierce County Health Careers Council to encourage staff development and growth within the healthcare industry;
- Franciscan Foundation offers annual scholarships available for current employees to advance their education;
- FHS hospitals serve as clinical training sites for a variety of health care specialties; and
- FHS works closely with agency personnel to negotiate rates and to ensure that the agency staff are able to provide the same high quality skill level that FHS requires of its own employees.
  [source: Application, pp186-187]

In response to this criterion, MultiCare Health System provided documentation to demonstrate that both it and FHS are having difficulty recruiting staff due to shortage of healthcare workers in Washington State as well as nationally. [source: MultiCare Health System, January 28, 2004, public comments, Appendices 24 and 25] It is clear from the data reviewed by the department that health care facilities, specifically hospitals, must consider all possibilities to manage the health care worker shortages. After reviewing data regarding health care worker shortages in Washington State, the department concludes that while a health care worker shortage exists in this state, and across the nation, this issue alone is not grounds for denial of this project. FHS provided, within its application, a comprehensive approach to recruit staff necessary for the additional beds. Further, denying a project solely on the current, system-wide health care worker shortages would not promote the development of needed services within a community.

Based on the information provided in the application, the department concludes that FHS provided a comprehensive approach to recruit and retain staff necessary for the new and existing hospitals. [source: Application pp185-188 and October 8, 2003, supplemental information, Attachment 6]

(2) *The proposed service(s) will have an appropriate relationship, including organizational relationship, to ancillary and support services, and ancillary and support services will be sufficient to support any health services included in the proposed project.*

FHS currently has the ancillary and support departments needed to operate its existing hospitals in Pierce and King County. FHS states it will license FHS-GH under its current SJMC hospital license, however, even with this licensure approach, additional ancillary and support services will be required. In response to this requirement, FHS states:

> *"this question involves two parts--the physical plant/environment and staffing. In terms of physical plant, the new hospital campus is being programmed and sized to meet demand for each service proposed to be located on the new campus. These services have been planned for expected initial volumes as well as future growth. Importantly, the equipment and departmental orientation will maximize the staffing efficiencies to the greatest extent possible. Given that this project proposes to establish a satellite campus, not a new hospital, FHS intends to utilize its most senior, most capable staff to oversee the start up and the initial*

operation of the campus. FHS is confident that all required ancillary and support services will be sufficiently sized, and the sufficient quality, to meet service demands." [source: Application, p188]

As indicated by FHS, some ancillary and support services will be provided through FHS or SJMC and some will be provided at the Gig Harbor site. Within the application, FHS did not provide draft ancillary/services agreements. Given that the hospital is not scheduled to open until approximately July 2007, ancillary and support service agreements have not yet been established. Based on the information provided in the application, the department concludes that FHS intends to meet this requirement, however, to ensure that appropriate agreements will be established, the applicant must agree to the following terms:

1) Prior to providing services at FHS-GH, the applicant will provide functional plans outlining the services to be provided through FHS, SJMC, and on site at FHS-GH.
2) Prior to providing services at FHS-GH, the applicant will identify the proposed medical director at FHS-GH and provide an executed copy of the medical director agreement.

Provided that the applicant agree to the terms outlined above, the department concludes that there is reasonable assurance that FHS-GH will have appropriate ancillary and support services, and this sub-criterion is met.

(3) There is reasonable assurance that the project will be in conformance with applicable state licensing requirements and, if the applicant is or plans to be certified under the Medicaid or Medicare program, with the applicable conditions of participation related to those programs.

As stated in the project description portion of this evaluation, FHS provides Medicare and Medicaid health services through its nine existing health care facilities. For this project, FHS intends to license FHS-GH under the SJMC hospital license. Within the most recent four years, the Department of Health's Office of Health Care Survey (OHCS), which surveys hospitals, dialysis centers, and hospice agencies within Washington State, has completed compliance surveys for the FHS facilities.[19] The surveys revealed minor non-compliance issues typical for the type of facility and FHS submitted plans of correction for the non-compliance issues. [source: compliance survey data provided by Office of Health Care Survey] Additionally, within the most recent three years, the Department of Social and Health Services, which surveys nursing homes within Washington State, completed compliance surveys on the skilled nursing facility owned and operated by FHS. Those surveys also revealed minor non-compliance issues, and FHS submitted plans of correction for the non-compliance issues. [source: compliance survey data provided by Department of Social and Health Services]

Given the compliance history of all of the health care facilities owned and/or operated by FHS, there is reasonable assurance that FHS would operate FHS-GH in conformance with applicable state and federal licensing and certification requirements. This sub-criterion is met.

[19] Hospital surveys conducted--St. Clare-2001 and 2003; St. Francis-2000 and 2003; and St. Joseph-2001 and 2003. Dialysis facility surveys conducted--Greater Puyallup Dialysis Center--2000 and 2002; St. Joseph Tacoma dialysis facility-2000 2003; Gig Harbor Dialysis Center--2004. Franciscan Hospice last surveyed in 1997. FHS Hospice Care Center is not yet operational, therefore a survey has not been conducted.

(4) *The proposed project will promote continuity in the provision of health care, not result in an unwarranted fragmentation of services, and have an appropriate relationship to the service area's existing health care system.*

With this project, FHS anticipates it will promote continuity in the provision of health care to the residents of the Gig Harbor and Key Peninsula service area by improving local access to health care services for a growing community. Given that the new hospital will also be part of the FHS healthcare system, FHS-GH will participate in the existing working relationships with local nursing homes and other health services in the service area. FHS is also an exclusive provider of inpatient services for Group Health Cooperative enrollees residing in Pierce County. Establishment of the new hospital in Gig Harbor will ensure improved access for the Group Health enrollees residing within the Gig Harbor/Peninsula area. [source: application, pp188-189]

The department acknowledges that establishment of a hospital in Gig Harbor will assist FHS by ensuring that patients are moved as quickly as possible to the appropriate care setting; and improving the timeliness of patient flow.

Further, FHS has been providing health care to the residents of central Pierce County for many years and participates in relationships with community facilities to provide a variety of post acute care services. Approval of this project will not change the current relationships in place with the health care providers in the service area.

Based on the above information, the department concludes that there is reasonable assurance that the establishment of a new hospital in Gig Harbor will assist in FHS's ability to continue to promote continuity of care. Further, FHS's relationships within existing health care system will continue and not result in an unwarranted fragmentation of services. This sub-criterion is met.

(5) *There is reasonable assurance that the services to be provided through the proposed project will be provided in a manner that ensures safe and adequate care to the public to be served and in accord with applicable federal and state laws, rules, and regulations.*

This sub-criterion is addressed in sub-section (3) above.

D. Cost Containment (WAC 246-310-240)

Based on the source information reviewed, the department determines that the applicant has met the cost containment criteria in WAC 246-310-240.

(1) *Superior alternatives, in terms of cost, efficiency, or effectiveness, are not available or practicable.*

Before submitting this application for review, FHS considered and dismissed three options. Those options and the reasons they were rejected by FHS are discussed below. [source: application, pp193-194]

Option 1-Do nothing

FHS states it quickly dismissed this option because it does not address any of the access, patient care, transportation, mission or efficiency issues detailed thought this application. SJMC's current high census level increasingly results in delays, diversions, and considerable movement of patients between rooms and units in an attempt to accommodate acuity and patient demographics.

Option 2-Further expand outpatient presence in Gig Harbor/Peninsula thereby eliminating the need to apply for a Certificate of Need.

Currently, FHS and SJMC operate several outpatient services in the Gig Harbor/Peninsula area. Services include a large outpatient center with physician offices and diagnostic services, an ambulatory surgery center, and a six-station dialysis center. While further establishing outpatient services in Gig Harbor would address some of the need for additional capacity, FHS ultimately concluded that this option was not the best alternative for the following three reasons.

1) An outpatient center would not address the EMS/Medic 1 need for a 24-hour medical director staffed emergency room in the Gig Harbor/Peninsula service area;
2) Significant concerns were raised that an outpatient only presence would, over time, lead to even greater market share for FHS-West hospitals. Without adequate inpatient bed capacity to support the market share, current access issues would be exacerbated;
3) An outpatient only presence does not address the need for improved access and local hospital presence for the more than 4,000 residents of the Gig Harbor/Peninsula area that are hospitalized annually and the 3,500 residents that are transported via ambulance to downtown Tacoma hospital, or diverted to other hospitals, annually.

Option 3-Increase acute care beds at SJMC in Tacoma

FHS's development planners determined that adding new beds at SJMC is significantly more costly and definitely more disruptive than constructing a community hospital campus on the Gig Harbor/Peninsula. This is due to the confined construction area, the need to work around patient care areas and staff, and the high-rise nature of the existing SJMC facility. Additionally, the SJMC downtown campus is only 9.97 acres and is nearing development capacity. FHS contends that the remaining capacity must be retained for future tertiary-level expansion at the hospital.

After considering all options, FHS chose to establish a 112-bed hospital in the Gig Harbor/Peninsula service area. Establishment of this new hospital would add 112 additional acute care beds to SJMC, the central Pierce County planning area, and Washington State as a whole.

Both MultiCare and HMH provided concerns related to the cost containment criterion. Excerpts from those concerns are below. [source: HMH January 27, 2004, public comment, p15; MultiCare January 28, 2004, public comment, p3]

HMH comments

Introduction of one more hospital in a region that has adequate capacity to serve the residents of the region, currently and for the future, would harm economies of scale and increase overall costs.

MultiCare comments

The applicant has failed to demonstrate that there are not more cost effective, efficient alternatives available, including the most obvious one: continuing to serve the Gig Harbor population at the existing Tacoma hospital, all of which have capacity for years to come. This alternative avoids the $94,563,078 estimated cost of the project altogether. Further, MultiCare could open up as many as 84 beds, at a small fraction of the per bed cost of the applicant's facility, in its new shelled-in and newly completed hospital wing. This s a much

more cost effective alternative to the applicants proposed expenditure. MultiCare is currently in the planning process to open additional beds.

As noted above, both HMH and MultiCare state that additional bed capacity is not needed in the central Pierce planning area, however, MultiCare also contradicts itself by adding that it is in the planning process to open additional beds. Based on the numeric methodology calculated by the department, the need for additional beds, while not immediate, is imminent in the near future, specifically by year 2008.

Given the amount of planning that must occur before a new hospital can be built and become operational, submission of this application in year 2004, and planning to become operational in midyear 2007 is reasonable. Based on the information provided in the application, public comments received in support of the application, and CHARS data obtained to verify assertions made by the applicant and affected parties, the department considers the establishment of an 80-bed hospital to be the best available option for the community. This sub-criterion is met.

(2) In the case of a project involving construction:

(a) The costs, scope, and methods of construction and energy conservation are reasonable;
As stated in the project description portion of this evaluation, this project involves construction. This sub-criterion is evaluated within the financial feasibility criterion under WAC 246-310-220(2).

(b) The project will not have an unreasonable impact on the costs and charges to the public of providing health services by other persons.
This sub-criterion is also evaluated within the financial feasibility criterion under WAC 246-310-220(2).

Based on the above evaluation, the department concludes that costs, scope, and methods of construction and energy conservation are reasonable and the project will not have an unreasonable impact on the costs and charges to the public of providing health services by other persons.

APPENDICES